ABBEY PAIN ASSESSMENT SCALE (FOLLOW ON ASSESSMENT)

DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME
VOCALISATION eg. whimpering, groaning, crying *Absent 0 Mild 1 Moderate 2 Severe 3*										
FACIAL EXPRESSION eg: looking tense, frowning grimacing, looking frightened *Absent 0 Mild 1 Moderate 2 Severe 3*										
CHANGE IN BODY LANGUAGE eg: fidgeting, rocking, guarding part of body, withdrawn *Absent 0 Mild 1 Moderate 2 Severe 3*										
BEHAVIOURAL CHANGE eg: increased confusion, refusing to eat, alteration in usual patterns *Absent 0 Mild 1 Moderate 2 Severe 3*										
PHYSIOLOGICAL CHANGES eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor *Absent 0 Mild 1 Moderate 2 Severe 3*										
PHYSICAL CHANGES eg: skin tears, pressure areas, arthritis, contractures, previous injuries *Absent 0 Mild 1 Moderate 2 Severe 3*										
Total score =										
Signature of person completing score										

0-2	3-7	8-13	14 +
NO PAIN	**MILD PAIN**	**MODERATE PAIN**	**SEVERE**

The Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.

The Abbey pain scale does not differentiate between distress and pain, therefore measuring the effectiveness of pain relieving interventions is essential.

The pain scale should be used as a **movement based assessment** , therefore observe the patient while they are being moved, during pressure area care, while showering etc.

A second evaluation should be conducted **1 hour after** any intervention taken. If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate.

Complete the scale hourly until the patient scores mild pain then 4 hourly for 24 hours treating pain if it recurs.

If the pain/distress persists, undertake a comprehensive assessment of all facets of the patients care and monitor closely over 24 hours including further intervention undertaken.

If there is no improvement during that time notify the doctor/pain team of the pain scores and actions taken.

Addressograph

Abbey Pain Scale
For measurement of pain in patients who cannot verbalise.

Name and designation of person completing the scale: ……

Date: ……Time: ……

How to use scale: While observing the patient, score questions 1 to 6

Q1. Vocalisation **Q1**
eg. whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3

Q2. Facial expression **Q2**
eg: looking tense, frowning grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3

Q3. Change in body language **Q3**
eg: fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3

Q4. Behavioural Change **Q4**
eg: increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3

Q5. Physiological change **Q5**
eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3

Q6. Physical changes **Q6**
eg: skin tears, pressure areas, arthritis, contractures, previous injuries.
Absent 0 Mild 1 Moderate 2 Severe 3

Add scores for 1 - 6 and record here ⇒ **Total Pain Score**

Now tick the box that matches the Total Pain Score ⇒

0 - 2 No pain	3 - 7 Mild	8 - 13 Moderate	14 + Severe

Finally, tick the box which matches the type of pain ⇒

Chronic	Acute	Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002
(This document may be reproduced with this acknowledgement retained)